Alaska Center for Dermatology, P. C.

3841 Piper Street | Suite T4-020 | Anchorage, AK 99508 | telephone 907.646.8500 | fax 907.646.9760

Patient Registration Form

Patient Name _____ _____ _____ Date of Birth _____/_____/_____
first middle initial last

Nickname _____SS# _____/_____/_____ Sex: ☐ M ☐ F

Email Address: _____

Mailing Address:_____ _____ _____ _____
city state zip

Which phone number would you like to designate as your **primary number**? ☐ Cell ☐ Home ☐ Work

Cell Phone	**Home Phone**	**Work Phone**
_____	_____	_____
Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message	Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message	Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message

Emergency Contact Name_____

Phone(s)_____ Relationship to Patient _____

Do you authorize us to communicate with another individual, such as spouse or relative? If so, please indicate below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Primary Insurance	**Secondary Insurance**
Ins Co Name_____	Ins Co Name_____
Subscriber ID#_____	Subscriber ID#_____
Subscriber Name_____	Subscriber Name_____
Subscriber DOB_____ Relationship to Pt_____	Subscriber DOB_____ Relationship to Pt_____

Responsible Party for Minor *If patient is a minor, the parent accompanying them today is the Responsible Party. This information will also apply to patients who have a designated legal guardian. Responsible Party must sign Assignment and Release below.*

RP Name _____Date of Birth ____/_____/_____SS# _____/_____/_____

Mailing Address:_____ _____ _____ _____
city state zip

Assignment and Release *I authorize the release of any information to my referring physician. I authorize Alaska Center for Dermatology to furnish my information to insurance carriers upon their written request and I assign to Alaska Center for Dermatology all payments for medical services rendered.*

_____ _____

Patient Signature (RP, if Patient is a Minor) **Date**

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Dermatology Intake Form

Patient Name_____**Date of Birth**_____

Occupation_____ **Preferred Pharmacy & Location**_____

Who is your primary care provider? (MD, NP, PA-C, etc) _____

Were you referred for this appointment? ☐ Yes ☐ No **If so, by whom?** _____

Medication/Allergies

Do you take any prescription or non-prescription medication? If yes, list with dosage. ☐ Yes ☐ No

_____

Please list all allergies to medication: ☐ No Known Drug Allergies

_____

Skin	Yes	No	
Do you have a personal history of melanoma?	☐	☐	
Have you ever had skin cancer?	☐	☐	If Yes, what type? _____
Has anyone in your family had skin cancer?	☐	☐	If Yes, what type? _____
Do you have a history of any specific skin diseases?	☐	☐	If Yes, please list: _____
Do you have problems with healing?	☐	☐	
Do you develop keloids after surgery?	☐	☐	
Do you bleed easily?	☐	☐	

Do you develop skin rashes in reaction to ☐ Medications? ☐ Food? ☐ Environment?

If Yes, please explain: _____

Medical History

Do you currently have or have you ever had:

☐ Asthma ☐ COPD ☐ Tuberculosis ☐ High blood pressure ☐ Heart attack ☐ Afib ☐ Stroke

☐ Diabetes ☐ Arthritis ☐ Hyperthyroid ☐ Hypothyroid ☐ Artificial Joints ☐ Hepatitis B/C ☐ HIV/AIDS

History of Cancer? ☐ Yes ☐ No If Yes, what type and where: _____

If Yes, what was your treatment:_____

Do you have a pacemaker? ☐ Yes ☐ No If Yes, does it have a defibrillator? ☐ Yes ☐ No

List any surgeries you have had in the last six months: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Prefer not to answer **Preferred Language**:_____

Race: ☐ Caucasian or European American ☐ African American ☐ Asian or Asian American

☐ Native Alaskan or Native American ☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to answer

Smoking Status:

☐ Never smoked

☐ Current every day smoker

☐ Current some day smoker

☐ Former smoker

Women:

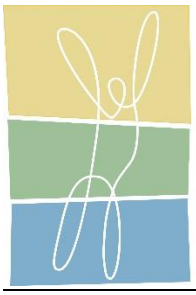
Are you pregnant or trying to conceive? ☐ Yes ☐ No

If you are currently pregnant, what is your due date? _____

Are you currently breastfeeding? ☐ Yes ☐ No

Signature _____**Date**_____

(Patient, Or Guardian if Minor)



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RELEASE OF MEDICAL INFORMATION/ CONTACT PERMISSION

In the event that we need to contact you (patient) regarding medical information about an appointment, lab/biopsy result, medication, or any other reason, it is permissible to release your information:

Leave a message on an answering machine/voicemail? _____ YES _____ NO

Speak with spouse / significant other? _____ YES _____ NO

Name:_____ Phone number: _____ Relationship:_____

Speak with other family members? _____ YES _____ NO

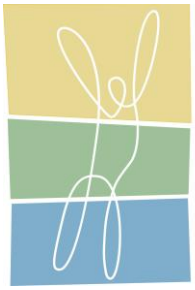
Name(s): _____ Phone number: _____ Relationship:_____

- OR -

I DO NOT authorize my medical information to be released to anyone _____ (Initial)

_____ _____ _____

Patient (or responsible party) Signature Patient PRINTED Name Date



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NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE – December 1, 2016

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY. This notice applies to Alaska Center for Dermatology and the doctors and other healthcare providers practicing at this facility.

It is our legal duty and we are required by law to protect the privacy of your information and to notify you of certain breaches of your information. We are providing this notice so that we can explain our privacy practices. We will follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time. For more information about our privacy practices or to place a complaint or report a concern or conflict, call the number listed below:

United Derm Partners
Angie Mangum, Privacy Officer
615-468-3694

Or, if you prefer to remain anonymous, you may call the toll-free number listed next and an attendant will handle your concern anonymously 1-888-893-9004.

You may also send a written complaint to the United States Department of Health and Human Services if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate address or visit http://www.hhs.gov/ocr/privacy/. Under no circumstance will you be retaliated against for filing a complaint.

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. For example, we may use your information in treatment situations if we need to send your medical record information to a specialist or physician as part of a referral for continuing care. We will send your health information and other identifying information to Medicare, Medicaid or other health insurance plans for our billing purposes. Your information will be used when processing your medical records for completeness and to compare patient data as part of our efforts to continually improve our treatment methods. We may disclose your information to our business associates we contract with to provide service on our behalf that requires the use of your health information. We may contact you or disclose certain parts of your health information to our

associate or related foundations, for fundraising purposes. You have the right to opt out of receiving such fundraising communications. We may share certain information with a person(s) you identify as a family member, relative, friend, or other person that is directly involved in your care or payment for your care, or if it becomes necessary to notify these individuals about your location, general condition, or death. In addition, we may need to disclose medical information about you to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status, and location.

Under certain circumstances we may be required to disclose your health information without your specific authorization. Examples of these disclosures are: requirements by state and Federal laws to report cases of abuse, neglect, or other reasons requiring law enforcement; for public health activities; to health oversight agencies; for judicial and administrative proceedings; for death and funeral arrangements; for organ donation; for special government functions including military and veteran requests, and to prevent serious threat to health or public safety. We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health related services that may be of benefit to you. Most uses and disclosures of psychotherapy notes, those for marketing purposes, and those that constitute a sale of medical information will only be made with your written authorization. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Do remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request except to the extent that we may have already acted.

As a patient, you have rights regarding how your information can be used and disclosed. These rights include access to your health information. In most cases, you have the right to look at or receive a copy of your health information. This may take up to 30 days to prepare and there may be a preparation fee associated with making any copies. You can ask for an accounting of disclosures. This is a list of instances in which we have disclosed your information for reasons other than treatment, payment and operations that you have not specifically authorized but that we are required to do by law (see section on how your information may be used and disclosed). We can provide you one list per year without charge; all additional requests in the same year will be subject to a nominal charge. If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend or correct the existing information. There may be some reasons that we cannot honor your request for which you submit a statement of disagreement. You can also request that your health information be communicated to you at an alternate location or address that is different from the one we received when you were registered. If you pay for your service in full up front, you can ask that we not disclose information about your treatment to your health plan. Finally, you can request in writing that we not use or disclose your information for any reasons described in this notice except to persons involved in your care or when required by law, or in emergency circumstances. We are not legally required to accept such a request but we will try to honor any reasonable requests.

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CONDITIONS OF TREATMENT

Medicaid

Thank you for choosing us at Alaska Center for Dermatology ("Practice," "us," "we," "our") as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your health. This Conditions of Treatment document outlines several of our policies that impact you, as well as certifications and consents that you provide to us to enable us to use your information for various purposes that are part of our relationship with you. Therefore, if you have any questions or concerns about any of the policies, certifications, or consents contained below, please do not hesitate to ask our staff.

1. **FINANCIAL POLICY:**
    - Insurance coverage is not a guarantee of payment. Co-payments must be made at time of service.
    - We verify eligibility at the time of service. If you are ineligible for coverage you will be responsible for charged incurred during any ineligibility period.
    - If Medicaid denies any claim due to other health insurance, it is your responsibility to update that information with Medicaid. If you fail to do so, you will be responsible for the affected date(s) of service.
    - In the event your insurance company does not pay the claim within a reasonable amount of time (45 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
    - If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit in full becomes your responsibility.
    - It is the policy of this office that the adult presenting a child/minor for treatment is responsible for payment.
    - Cosmetic procedures will not be billed to insurance and the cost of the procedure will be due at time of service. Your provider will determine if procedures are cosmetic or medically necessary.

2. **FINANCIAL AGREEMENT: The undersigned in consideration of the services to be rendered to the patient is obligated to pay the Practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical Practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the Practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.**

3. **CONSENT TO EMAIL, CALLS AND TEXT COMMUNICATIONS:** These messages will not include Protected Health Information (PHI) or clinical information. If at any time you provide an email address or residential or wireless/mobile telephone number to the Practice, **you give your prior written consent to receive emails, calls and text messages for service-related communications to such email address(es) and phone number(s).** Emails, voicemails and text messages have inherent privacy risks, especially when access to your computer or mobile device is not password protected, is shared by others, or access is provided by your employer or public facility. Further, consenting to receive emails, calls, and/or text messages from the Practice, you understand and acknowledge that communications transmitted via unencrypted email or via text messages over an open network are unsecure, and could be accessed by an unauthorized third party in transit. Please do not send any information that is considered especially sensitive through these communication channels (e.g., medical diagnosis information, personal health history), as it may be received or accessed by unintended recipients, intercepted, altered or used without authorization or detection.

You may notify the Practice if you wish to opt out of certain email messages, phone calls and text messages. Please understand that you may continue to receive services communications via email, however, in order for us to fulfill a request or communicate with you about your account. In addition, we may still respond to any communications you initiate and send to us, including via phone or text, in order to respond to your request or question even if you have previously told us that you do not wish to be contacted using those communication methods.

- Message and data rates may apply.
- Please also note that messages are unencrypted, and unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties, and/or stored or archived by service providers and system operators.
- You certify that you are the user and/or subscriber of any email address and telephone number you provide to Practice and accept responsibility for email, call and text communications sent to or from this address or number. You agree to notify Practice in writing in the event your email address or telephone number changes.

  Service-Related Communications: Service-related communications that you consent to receive include but are not restricted to communications regarding billing and payment for products and services, appointment reminders, and other healthcare communications and communications about your condition(s), care, treatment, referrals or appointment(s).

By signing below, you certify that you are the user and/or subscriber of the email address and/or mobile number previously provided, and accept full responsibility for emails and/or text messages sent to or from this address or number. You agree to notify the Practice in writing in the event your email address or mobile number changes.

There may be a delay when responding to messages; thus, if you have an urgent situation, you should not rely on messages sent to the Practice to request assistance, but instead should seek assistance by means consistent with your needs (e.g., by contacting your provider/care team directly or calling 911).

To the extent permitted by law, you hereby agree to hold the Practice and its affiliates harmless from any and all claims and liabilities arising from or related to emails or text messages sent to the email address and/or number previously provided.

I have read and fully understand the above Conditions of Treatment and have been given the opportunity to ask questions.

Signature of patient (or legal guardian) Date

Email address:_____ Telephone:

If other than patient:

_____ _____

Relationship of Representative Reason individual is unable to sign (i.e. minor or legally incompetent etc).

_____ _____

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Authorization to Disclose Protected Health Information (PHI)

Note: Please fill out each section completely, and inquire if you have any questions. Thank you.

Patient Name _____ **DOB** _____

Phone Number(s) _____

Parent/Legal Guardian *(if applicable)* _____

- **I authorize release of the following:**
  - ☐ All PHI, including confidential
  - ☐ Specific PHI from services rendered between the dates of _____ and _____.
  - ☐ Specific PHI listed below

    _____

    _____
  - ☐ All PHI except confidential selected below*

    (Note: While specific confidential PHI will not be included, the information authorized for release may make reference to confidential findings.)

    *Confidential:
    ☐ HIV Test Results
    ☐ X-ray Reports
    ☐ Mental Health Treatment Records
    ☐ Lab Reports
    ☐ Clinic Notes for Doctors
    ☐ Alcohol & Drug Therapy
    ☐ Other (please specify): _____

I authorize the Alaska Center for Dermatology to release my PHI to:

_____

☐ Mail to: _____

_____

☐ Fax to: _____

☐ Call me at _____ when ready. I will pick up.

OR

I authorize the Alaska Center for Dermatology to obtain my PHI from:

_____

_____

_____

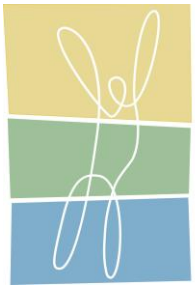
- **Purpose of PHI release:**
  - ☐ Transfer of records to another provider
  - ☐ Personal use
  - ☐ Legal use

- **This authorization is valid for:**
  - ☐ A one-time disclosure for treatment received on or prior to this request.
  - ☐ A continuing disclosure for treatment received on or prior to this request **and** for any **future** treatment of the type described above, not to exceed 12 months.

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. Unless I otherwise revoke this authorization in writing, it will expire either upon receipt of records or 12 months from the date of this authorization. At that time no express revocation shall be needed to terminate my authorization. I hereby release the Alaska Center for Dermatology or _____ *(originating facility, if not Alaska Center for Dermatology)* **from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released.**

_____ _____

Patient (or Legal Guardian) Signature **Date**



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HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With my consent, Alaska Center for Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Alaska Center for Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures. The practice provides this form to comply with the Health Information Portability and Accountability Act (HIPAA) of 1996.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Alaska Center for Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Alaska Center for Dermatology's Privacy Officer .

With my consent, Alaska Center for Dermatology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and others.

With my consent, Alaska Center for Dermatology may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements.

With my consent, Alaska Center for Dermatology may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements. I have the right to request that Alaska Center for Dermatology restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Alaska Center for Dermatology's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If l do not sign this consent, Alaska Center for Dermatology may decline to provide treatment to me.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

PATIENT'S NAME (PLEASE PRINT)